LPS Medication Administration Authorization Form

Child's Name:_____ **Birth date:**_____

School:_____ **Grade:**_____

Medication:_____

Dosage/Amount:_____**Route:**_____

To be given at the following time(s):_____

Purpose of medication:_____

Side effects that need to be reported:_____

Starting Date:_____ **Ending Date:**_____

Storage Requirements:_____

_____ _____

Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____ _____

Print name of Health Care Provider **Phone Number** **Date**

Prescription medication:

- **Must come in a container labeled with the child's name, name of medicine, time medicine is to be given, dosage, and licensed health care provider's name.**
- ***Please ask the pharmacist for a separate labeled medication bottle to keep at the school.***

Over the counter medication:

- **Must be packaged in the original container and be labeled with the child's name**
- **For safety reasons, parents are responsible for bringing the child's medication to the school health office**
- **Dosages that require a tablet or pill to be split must be split by the pharmacist or parent. School staff may not split tablets or pills.**
- **Unused medication that is not picked up by the parent will be discarded at *the end of the school year.***
- **New medication administration authorization forms must be completed each time there are any changes in medication or dosage and at the beginning of each school year.**

Littleton Public Schools agrees to administer medication prescribed by a licensed healthcare provider. It is understood that medication is administered solely at the request of, and as an accommodation to, the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by Littleton Public Schools, the undersigned parent or guardian hereby agrees to release the said institution and their personnel from any legal claim(s) which they now have, or may hereafter have, arising out of the administration of (or failure to administer) the medication to the student. ***By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school nurse or school staff delegated to administer medication.***

_____ _____ _____

ParentGuardian Name (Printed) **Parent/Guardian Signature** **Date**

_____ _____

Phone **Alternate Phone**

For School RN use only:

_____ _____

Nurse Signature **Date**

School Copy___ PMT_____ Scanned____ IC upload____